Quality Standards

Opioid Use Disorder

Care for People 16 Years of Age and Older

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Health Quality Ontario

Let's make our health system healthier

Ontario
Health Quality Ontario

Summary

This quality standard addresses care for people 16 years of age and older (including those who are pregnant) who have or are suspected of having opioid use disorder (also referred to as opioid addiction). The scope of this quality standard applies to all services and care settings, including correctional facilities.

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, people with lived experience, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that:

- Assist people and their families to know what to ask for in their care
- Assist care providers to know what care they should be offering, based on evidence and expert consensus
- Assist health care organizations measure, assess, and improve their performance in caring for people

The statements in this quality standard do not override the responsibility of care providers to make decisions with individuals, after considering each person's unique circumstances.

How to Use Quality Standards

Quality standards inform care providers and organizations about what high-quality health care looks like. They are based on the best available evidence.

They also include indicators to help care providers and organizations assess the quality of care they are delivering, and to identify gaps and areas for improvement. These indicators measure process, structure, and outcomes.

In addition, tools and resources to support care providers and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact qualitystandards@hqontario.ca.

About This Quality Standard

Scope of This Quality Standard

This quality standard focuses on care for people 16 years of age and older (including those who are pregnant) who have or are suspected of having opioid use disorder (also referred to as opioid addiction). The scope of the standard covers all services and settings, including correctional facilites, and all geographic regions of the province.

This quality standard includes 11 quality statements and 1 emerging practice statement addressing areas identified by Health Quality Ontario's Opioid Use Disorder Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with opioid use disorder.

Terminology Used in This Quality Standard

In this quality standard, "family" refers to family members, friends, or supportive people not necessarily related to the person with opioid use disorder. The person with opioid use disorder must give appropriate consent to share personal information, including medical information, with their family.

In this quality standard, the term "care provider" is used to acknowledge the wide variety of providers that can be involved in the care of people with opioid use disorder. The terms refers to health care providers, health care professionals, unregulated care providers, and volunteer and paid peer support workers. Our choice to use "care provider" does not diminish or negate other terms that a person may prefer.

In this quality standard, "opioid use disorder" is defined as "a problematic pattern of opioid use leading to clinically significant impairment or distress, occurring within a 12-month period." The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) lists 11 symptoms of opioid use disorder.

Why This Quality Standard Is Needed

Opioid use disorder is associated with clinically significant impairment or distress.[1] People with opioid use disorder have a mortality rate that is more than 10 times that of the general population.[2] Fatal opioid overdoses are one cause for this increased mortality rate. According to statistics from the Office of the Chief Coroner for Ontario, opioid overdose mortality rates increased 285% between 1991 and 2015.[3] In Ontario, approximately 1 in every 8 deaths among 25- to 34-year-olds is related to opioid use.[4] and 1 in every 10 drug overdose deaths in adults occurs within 1 year of release from correctional facilities.[5] In addition to the high risk of overdose, people with opioid use disorder are also at higher risk for death from a variety of other causes, such as cardiovascular conditions and infectious diseases.[2]

Opioid use disorder is a serious and life-threatening condition, and there are many opportunities to improve the quality of care provided to people with opioid use disorder.

Many people with opioid use disorder report being unable to access the care they need.[6] Ontario data show that opioid agonist therapy, a first-line treatment for opioid use disorder, is provided more often in urban locations than in rural or remote locations. Thus, people with opioid use disorder living outside urban centres may experience difficulty accessing this type of

therapy.[7] Some treatment facilities also currently prohibit the use of this evidence-based therapy; for example, roughly 1 in 4 residential addiction treatment programs in Ontario do not allow people to take opioid agonist therapy while participating in their programs (ConnexOntario.ca, May 2017).

Even when people are able to access opioid agonist therapy in Ontario, they do not always receive proper attention to their other basic health needs while receiving care for their opioid use disorder. For example, people receiving methadone therapy in Ontario are significantly less likely to be screened for cervical, breast, and colorectal cancer, and those with diabetes are less likely to receive diabetes monitoring than the general population.[8]

There is an urgent need to address the opioid crisis in Ontario. Key to this goal is addressing gaps in the quality of care that is currently provided to people with opioid use disorder across the province. Based on evidence and expert consensus, the 11 quality statements that make up this standard provide guidance on high-quality care, with accompanying indicators to help care providers and organizations monitor and improve the quality of care they provide.

In addition to this quality standard, Health Quality Ontario has developed two further quality standards related to opioids: *Opioid Prescribing for Acute Pain* and *Opioid Prescribing for Chronic Pain*.

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect and equity.

People with opioid use disorder should receive services that are respectful of their rights and dignity and that promote self-determination. They should be given the same care and be treated with the same degree of respect and privacy as any other person. Although not completely understood, addiction appears to be associated with psychological and social factors, particularly adverse childhood experiences such as neglect and abuse.

Care for people with opioid use disorder should be guided by a trauma-informed approach. With this approach, it is not necessary for the person to disclose their trauma; rather, this approach acknowledges how common trauma is among people who use substances and seeks to connect those interested in treatment with appropriate trauma services.

People with opioid use disorder should receive services that are respectful of their gender identity, sexual orientation, socioeconomic status, education, intellectual capabilities, housing, age, background (including self-identified cultural, ethnic, and religious background), and disability.

People with opioid use disorder benefit from care provided by a care provider or care team with the knowledge, skill, and judgment to provide evidence-based treatment for opioid use disorder while also receiving care that addresses all of their primary health care needs.

Care providers should be aware of the historical context of the lives of Canada's Indigenous peoples and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities.

A high-quality health system is one that provides appropriate access, experience, and outcomes for all Ontarians no matter where they live, what they have, or who they are.

How We Will Measure Our Success

A limited number of overarching goals are set for this quality standard; these objectives have been mapped to indicators to measure the success of this quality standard as a whole:

- Rate of opioid-related deaths (measureable)
- Urgent hospital use:
    - Rate of opioid-related emergency department visits (measureable)
    - Rate of opioid-related hospital admissions (measureable)
- Percentage of people in treatment for opioid use disorder who reported improved quality of life (not measureable)
- Percentage of people in treatment for opioid use disorder who reported improved functional outcomes, including the following:
    - Treatment retention at 12 months (not measureable)
    - Return to work and/or work retention (not measureable)
    - Social functioning (not measureable)
    - Physical functioning (not measureable)
- Percentage of primary care providers (family physicians and nurse practitioners) who have prescribed opioid agonist therapy in the last year (measureable)

In addition, each quality statement within this quality standard is accompanied by one or more indicators. These indicators are intended to guide measurement of quality improvement efforts related to implementation of the statement.

Quality Statements in Brief

QUALITY STATEMENT 1:
Identifying and Diagnosing Opioid Use Disorder
People at risk of opioid use disorder are asked about their opioid use and are further assessed as appropriate.

QUALITY STATEMENT 2:
Comprehensive Assessment and Collaborative Care Plan
People diagnosed with opioid use disorder have a comprehensive assessment and a care plan developed in collaboration with their care providers.

QUALITY STATEMENT 3:
Addressing Primary Care and Social and Mental Health Needs
People with opioid use disorder have integrated, concurrent, culturally safe management of their primary care, mental health, and social needs.

QUALITY STATEMENT 4:
Information to Participate in Care
People with opioid use disorder are provided with information to enable them to participate in their care. If family is involved, they are also provided with this information.

QUALITY STATEMENT 5:
Opioid Agonist Therapy as First-Line Treatment
People with opioid use disorder are informed that opioid agonist therapy is a safer and more effective treatment option than treatments that do not include opioid agonist.

QUALITY STATEMENT 6:
Access to Naloxone and to Overdose Education
People with opioid use disorder, and their families, have immediate access to naloxone and to overdose education.

QUALITY STATEMENT 7:
Access to Opioid Agonist Therapy
People diagnosed with opioid use disorder have access to opioid agonist therapy as soon as possible, within a maximum of 3 days following their diagnosis.

QUALITY STATEMENT 8:
Concurrent Mental Health Disorders
People with opioid use disorder who also have a mental health disorder are offered concurrent treatment for their mental health disorder.

QUALITY STATEMENT 9:
Treatment of Opioid Withdrawal Symptoms
People with opioid use disorder who are in at least moderate withdrawal from opioids are offered relief of their symptoms with buprenorphine/naloxone within 2 hours.

QUALITY STATEMENT 10:
Tapering Off of Opioid Agonist Therapy
People with opioid use disorder who have achieved sustained stability on opioid agonist therapy who wish to taper off are supported in a collaborative slow taper if clinically appropriate.

QUALITY STATEMENT 11:
Harm Reduction
People with opioid use disorder have same-day access to harm reduction services. A comprehensive harm reduction approach includes education, safe supplies, infectious disease testing, vaccinations, appropriate referrals, and supervised consumption services.

Quality Statement 1: Identifying and Diagnosing Opioid Use Disorder

People at risk of opioid use disorder are asked about their opioid use and are further assessed as appropriate.

Background

People at risk of opioid use disorder should be asked by care providers if they are using opioids. If a person at risk states that they are using opioids, their care provider should engage them in a discussion regarding the type of opioid they are using, the method of administration, the frequency of administration, and the quantity of opioids being used.[9] If it is possible that a person's opioid use is causing them significant impairment or distress, the person should be assessed for opioid use disorder via the most current *Diagnostic and Statistical Manual of Mental Disorders* criteria.[1]

Source: National Institute for Health and Care Excellence, 2007[9]

Definitions Used Within This Quality Statement

People at risk of opioid use disorder
People at risk of opioid use disorder meet one or more of the following criteria:

- Receive care in or have a history of involvement with the criminal justice system
- Receive care in a mental health setting
- Have been prescribed long-term opioid therapy for chronic pain (see the quality standard *Opioid Prescribing for Chronic Pain*)
- Present with symptoms that suggest the possibility of opioid use disorder; for example, medical complications related to injection drug use (e.g., skin infections, abscesses, endocarditis, premature valve disease)

What This Quality Statement Means

For People With Opioid Use Disorder
Your care provider may talk with you about your opioid use if they are worried that opioids are having a negative impact on your life or are putting you at risk of harm. Your care provider should not judge you and should treat you with care and respect.

For Care Providers
People at risk of opioid use disorder should be screened and, if necessary, provided with a more thorough assessment for a possible diagnosis of opioid use disorder.

For Health Services
Systems and resources should be in place to allow for care providers to screen all those at risk of opioid use disorder.

Quality Indicators

Process Indicator

Percentage of people at risk of opioid use disorder who are asked about their opioid use

- Denominator: total number of people classified as being at risk of opioid use disorder (see definition)
- Numerator: total number of people in the denominator who are asked about their opioid use (type of opioid they are using, method of administration, frequency of administration, and quantity being used)
- Data source: local data collection

Quality Statement 2: Comprehensive Assessment and Collaborative Care Plan

People diagnosed with opioid use disorder have a comprehensive assessment and a care plan developed in collaboration with their care providers.

Background

A comprehensive assessment and care plan help identify complications of opioid use and other medical, social, and mental health concerns.[10] Care providers should give evidence-based information about the condition and assess the person's goals to determine the most appropriate level of expertise needed to provide care.[9] The care plan should be reassessed regularly until the person's goals are met.[11]

Sources: National Institute for Health and Care Excellence, 2007[9] | Registered Nurses' Association of Ontario, 2015[11]

Definitions Used Within This Quality Statement

Comprehensive assessment
A comprehensive assessment should address, at a minimum, the following items:

- The person's goals for treatment
- Opioid use and overdose risk
- Physical health status and medical conditions
- Mental health (see statement 8)
- Other substance use (e.g., alcohol, benzodiazepines, tobacco)
- Potential infections resulting from drug use
- Socioeconomic information
- Trauma screen*
- Family history of substance use and mental health disorders*
- Resilience and strengths*
- Biological testing (e.g., urine drug screens)*

*Secondary care providers (e.g., cardiologists, infectious disease specialists) are not expected to complete the entire comprehensive assessment. The asterisk indicates items that can be deferred as long as the secondary care provider refers the person to another provider who will complete the assessment. Care providers working in urgent care settings should complete the entire comprehensive assessment and create the care plan. At times, completion of the comprehensive assessment and care plan may need to be deferred until acute issues are addressed.

Care plan
When establishing a care plan with a person with opioid use disorder, care providers should, at minimum, address the following[9,10]:

- Management of the person's opioid use disorder, including the following:
  - Same-day access to harm reduction services including education, safe supplies, infectious disease testing, vaccinations, appropriate referrals, and supervised consumption services
  - Access to ongoing treatment within 3 days
  - Access to naloxone and overdose education
- Treatment of other current substance use (e.g., use of alcohol, benzodiazepines, tobacco)
- Housing, and occupationalneeds
- Income support
- Connection with a primary care provider
- Psychological and pharmacological treatments for concurrent mental health disorders (see statement 8)

What This Quality Statement Means

For People With Opioid Use Disorder
If you are diagnosed with opioid use disorder, and if you agree, your care provider will do an assessment with you. Your care provider will ask about things like your use of opioids, your physical health, your mental health, and any housing or income concerns you may have. After doing this assessment, your care provider will work with you to make a care plan that addresses all of your needs. If you choose, your family can help you make your care plan.

For Care Providers
Once you have diagnosed a person with opioid use disorder, and if the person agrees, perform a comprehensive assessment and complete a care plan with the person as soon as possible. Continue to reassess the person during subsequent visits, and adjust the plan accordingly until the goals of the plan are met.

For Health Services
Ensure systems, processes, and resources are in place to assist care providers with performing comprehensive assessments and creating care plans for people with opioid use disorder. This includes providing the time required for care providers to conduct comprehensive assessments and ensuring access to the resources necessary to develop and maintain (or adjust as appropriate) care plans.

Quality Indicators

Process Indicators

Percentage of people with opioid use disorder who receive a comprehensive assessment
Denominator: total number of people with opioid use disorder

- Numerator: total number of people in the denominator who receive a comprehensive assessment
- Data source: local data collection

Percentage of people with opioid use disorder who receive a care plan

- Denominator: total number of people with opioid use disorder for whom a comprehensive assessment is completed
- Numerator: total number of people in the denominator who receive a care plan
- Data source: local data collection

Percentage of people with opioid use disorder with a care plan who developed their care plan in collaboaration with their care provider

- Denominator: total number of people with opioid use disorder with a care plan
- Numerator: total number of people in the denominator who developed their care plan in collaboration with their care provider
- Data source: local data collection

Quality Statement 3: Addressing Primary Care and Social and Mental Health Needs

People with opioid use disorder have integrated, concurrent, culturally safe management of their primary care, mental health, and social needs.

Background

It is important that people with opioid use disorder be provided with nonjudgmental, culturally supportive care that extends beyond addressing their opioid use disorder to include primary care, mental health, and social needs.[10] (See also statements 2 and 8)

The initiation and maintenance of opioid agonist therapy with buprenorphine/naloxone or methadone can be done in primary care, integrated care (primary care and addiction care) or specialized clinic settings. Care providers in specialized clinic settings should encourage and support a transition to primary care providers for those receiving ongoing treatment with buprenorphine/naloxone. Those providing treatment with either buprenorphine/naloxone or methadone in specialized clinic settings should ensure that people receiving opioid agonist therapy also have their primary care, mental health, and social needs addressed concurrently either in the specialized clinic or via other care providers

In addition to physical and mental health care needs, the social needs of people with opioid use disorder, including housing and income support, should be addressed. Stress-management strategies and tools for preventing relapse should be discussed.[12] Where appropriate, referrals to health and social services, such as peer-support groups, cultural supports, and vocational and skills training, should be provided.[10]

Source: Advisory committee consensus

What This Quality Statement Means

For People With Opioid Use Disorder
There may be more than one care provider helping you manage your opioid use disorder. Often, your family doctor or nurse practitioner can provide at least part of your addiction treatment. If you need additional help, they can connect you with other care providers who can help you with any other health or mental health care needs you have. They can also connect you with people who can help with things like finding housing, a job, or financial support.

For Care Providers
Provide support and referrals to address the person's primary care, mental health, and social needs. If you are not able to provide these on site, you are responsible for facilitating access to them elsewhere. Offer applicable referrals for peer-support groups, cultural supports, and vocational and skills training supports.

For Health Services
Ensure systems, processes, and resources are in place to assist care providers with addressing the physical and mental health care and social needs of people with opioid use disorder. This includes ensuring care providers have the time and resources required to provide counselling and comprehensive physical and mental health care to people with opioid use disorder. Pathways should be in place to facilitate referrals to health and social services when appropriate.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who receive regular primary care

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who receive regular primary care
- Data source: local data collection

Structural Indicator

Local availability of comprehensive addiction management program spots that provide culturally safe care for opioid use disorder and address primary care, mental health, and social needs

- Data source: local data collection

Quality Statement 4: Information to Participate in Care

People with opioid use disorder are provided with information to enable them to participate in their care. If family is involved, they are also provided with this information.

Background

High-quality care involves a partnership between care providers and the person with opioid use disorder.[10] Care providers bring their expertise, and the person with opioid use disorder brings their knowledge of the impact that opioid use disorder has on their life, as well as their goals for management. Information about opioid use disorder can improve the ability of people and their families to navigate the health system and optimize their use of appropriate resources.

Source: Advisory committee consensus

Definitions Used Within This Quality Statement

Information
Information about opioid use disorder should be provided throughout the care continuum verbally and/or in a printed or multimedia format. This information should include, at minimum, content related to the following:

- Diagnosis
- Elements of the care plan (see statement 2)
- Care providers involved in implementing the care plan
- How to recognize and respond to a potential opioid overdose (see statement 10)
- Information about available treatment options and harm reduction services (see statement 11); this should include details about the following:
    - Treatment and harm reduction objectives
    - Treatment and harm reduction duration
    - Potential treatment-related side effects
    - Potential long-term outcomes of treatment and harm reduction strategies
    - Costs, risks, and benefits associated with treatment and harm reduction strategies

What This Quality Statement Means

For People With Opioid Use Disorder
Throughout your care journey, your care provider should give you information about opioid use disorder. They should tell you about all of your treatment and harm reduction options, and the different care providers who might be involved in your care. This information should be given to you in a variety of ways, including verbally, written down, or in a video. If you choose to have family involved in your care, they should also be given this information. You should be involved in all decisions made about your care.

For Care Providers
Provide evidence-based information that is tailored to meet the person's learning needs in a format and at times that are most appropriate for them. When family are involved in the person's care, and if the person consents, include family as much as possible in discussions and decision-making.

For Health Services
Ensure that appropriate educational resources are available for care providers to use with people with opioid use disorder. These resources should be available in written and multimedia formats and translated where necessary.

Quality Indicators

Process Indicators

Percentage of people with opioid use disorder who reported receiving information from their care provider for themselves, and their family as appropriate, to enable participation in their care

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who reported receiving information from their provider for themselves, and their family as appropriate, to enable participation in their care
- Data source: local data collection

Percentage of people with opioid use disorder who reported that their care provider involved them as much as they wanted in decisions about their care

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who reported that their care provider involved them as much as they wanted in decisions about their care
- Data source: local data collection

Quality Statement 5: Opioid Agonist Therapy as First-Line Treatment

People with opioid use disorder are informed that opioid agonist therapy is a safer and more effective treatment option than treatments that do not include opioid agonist therapy.

Background

People with opioid use disorder who are treated with opioid agonist therapy have better retention in addiction treatment, less use of addictive substances, improved health and social functioning, and lower rates of mortality than those who do not receive opioid agonist therapy.[13-15] Nearly all people who stop taking opioids without first being stabilized on opioid agonist therapy will relapse.[12] Relapse is particularly dangerous because a person who has stopped taking opioids has a reduced tolerance and is therefore at an increased risk of overdose and death.[12]

People with opioid use disorder who decline opioid agonist therapy should be offered a supervised slow opioid agonist taper, lasting longer than 1 month,[12] and should be offered concurrent psychosocial treatment.[16,17] They should also be offered continued treatment, support, and monitoring for at least 6 months.[17] All people who have stopped taking opioids should be counselled on the risks of overdose owing to a reduction in tolerance. They should also be provided with naloxone and taught how to administer it and how to recognize and respond to emergencies.[18]

Sources: Advisory committee consensus | British Columbia Centre on Substance Use, 2017[12]

What This Quality Statement Means

For People With Opioid Use Disorder
When you and your care provider work on your care plan, your care provider will explain the different types of treatments available to you. No matter where you seek treatment, you should be offered a treatment called opioid agonist therapy; this is sometimes called “maintenance therapy.” This treatment makes your care plan safer and more effective.

For Care Providers
Inform people with opioid use disorder that incorporating opioid agonist therapy into their care plan is recommended. However, treatment is ultimately the person’s decision; if they opt to forgo stabilization and opioid agonist therapy, their decision must be respected. If they decline opioid agonist therapy, inform them of the harms associated with immediate opioid cessation, and encourage a slow taper with buprenorphine/naloxone or methadone. Provide them with naloxone, instructions on overdose prevention, and contact information for harm reduction services. If family is involved in the person’s care, and if the person consents, the family should also be provided with naloxone, instructions on overdose prevention, and contact information for harm reduction services.

For Health Services
Ensure systems, processes, and resources are in place to ensure that accurate, evidence-based information on treatment options is provided to all people with opioid use disorder and their families as appropriate.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who are informed that opioid agonist therapy is a safer and more effective treatment option than treatments that do not include opioid agonist therapy

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who report being told that opioid agonist therapy is a safer and more effective treatment option than treatments that do not include opioid agonist therapy
- Data source: local data collection

Quality Statement 6: Access to Naloxone and to Overdose Education

People with opioid use disorder, and their families, have immediate access to naloxone and to overdose education.

Background

People with opioid use disorder and their families are more likely than the general population to experience or witness an opioid overdose.[18] People being released from a correctional facility are at particularly high risk of overdose following release, owing to a reduced opioid tolerance.[5]

All people with opioid use disorder, and their families as appropriate, should be provided with naloxone. They should be taught how to administer it and how to recognize and respond to a potential overdose. When administering naloxone, people should select a route of administration based on the formulation available, their administration skills, and the setting.[18]

Sources: British Columbia Centre on Substance Use, 2017[12] | World Health Organization, 2015[18]

Definitions Used Within This Quality Statement

Access to naloxone

Care providers working in all settings, including community clinics and services, pharmacies, hospitals, inpatient addiction programs, mental health care facilities, and correctional facilities, should provide people with naloxone and information on how to use naloxone and how to recognize and respond to a potential opioid overdose.

Overdose education

Overdose education should be provided to people when they are given naloxone. In the case of a potential opioid overdose, if a person does not respond to stimulation, it is important to take the following steps:

1. Call 911 to request emergency assistance
2. Perform chest compressions (may need to be repeated)
3. Administer naloxone (may need to be repeated)
4. Stay with the person until help arrives

What This Quality Statement Means

For People With Opioid Use Disorder

Naloxone is a drug that helps to reverse the effects of an opioid overdose long enough for you to get to the hospital. Your care provider should give you naloxone and should explain to you how to use it in emergencies cases where you or someone you know has an opioid overdose. If your family is involved in your care, your care provider should also give them naloxone and explain how to use it in case they need to administer it to you in an emergency.

For Care Providers

You should provide people with opioid use disorder, and their families as appropriate, with naloxone and instructions on how to administer the medication and how to respond in the case of a potential opioid overdose.

For Health Services
Ensure systems, processes, and resources are in place so that all people with opioid use disorder and their families have access to naloxone, are taught how to use it, and are provided with overdose education, regardless of where the person with opioid use disorder presents.

Quality Indicators

Process Indicators

Percentage of people with opioid use disorder and their families who receive naloxone and who receive overdose education

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who receive naloxone and overdose education
- Data source: local data collection

Percentage of people with opioid use disorder who receive naloxone and who receive overdose education when released from a correctional facility

- Denominator: total number of people with opioid use disorder released from a correctional facility
- Numerator: total number of people in the denominator who receive naloxone, and overdose education
- Data source: local data collection

Structural Indicator

Local availability of access to naloxone, and overdose education for people with opioid use disorder and their families

- Data source: local data collection

Quality Statement 7: Access to Opioid Agonist Therapy

People diagnosed with opioid use disorder have access to opioid agonist therapy as soon as possible, within a maximum of 3 days following their diagnosis.

Background

If a person with opioid use disorder chooses to receive opioid agonist therapy, prescribers should recommend either buprenorphine/naloxone or methadone.[14,15,19,20] Individual characteristics, preferences, and ease of accessibility to treatment should be considered when choosing between opioid agonist therapies. Buprenorphine/naloxone should be the treatment of choice in most cases, as it is a safer medication and more easily accessible than methadone in rural and remote locations.[12] Methadone is an alternative that may be more suitable for certain people.[12]

If a person receiving opioid agonist therapy enters an inpatient facility (e.g., a hospital or residential addiction treatment program) or is in a correctional facility, their opioid agonist therapy should be continued without disruption. All addiction treatment services and addiction care providers should permit the continued use of opioid agonist therapy for those currently receiving this treatment and also offer opioid agonist therapy and facilitate its access for those requesting initiation.

Sources: Advisory committee consensus (time frame) | British Columbia Centre on Substance Use, 2017[12] | Centre for Addiction and Mental Health, 2011[19]

Definitions Used Within This Quality Statement

Opioid agonist therapy
Opioid agonist therapy is the medical provision of opioid agonists in a strictly regulated environment with the goal of improving health outcomes and minimizing harms. The opioid agonists used are buprenorphine/naloxone or methadone. Opioid agonist therapy eliminates the cycle of intoxication and withdrawal, reduces opioid cravings, and blocks the effects of other opioids. Opioid agonist therapy does not have a well-defined time line. Some people can be tapered to discontinuation after a period of stability, whereas others may need to continue indefinitely. The length of treatment depends on the person, their social stability, the presence of concurrent mental health and/or substance use disorders, and the severity of their opioid dependence.

What This Quality Statement Means

For People With Opioid Use Disorder
Opioid agonist therapy reduces cravings for opioids and blocks the effects of other opioids. The medications used for this are either (1) a combination of buprenorphine and naloxone—also called Suboxone—or (2) methadone. Your care provider should talk with you about the differences between these two medications to help you make the best choice for you.

You should be given opioid agonist therapy within 3 days of being diagnosed with opioid use disorder, no matter where you first ask for treatment or where you receive treatment.

If you are already taking opioid agonist therapy and you go into a hospital, a residential addiction treatment program, or a correctional facility, your treatment should be continued without stopping at any time.

For Care Providers
If the person you are treating agrees to opioid agonist therapy, start them on buprenorphine/naloxone or methadone as soon as possible. Buprenorphine/naloxone should be the treatment of choice in most cases, especially if methadone is not locally available and requires extensive travel for the person to obtain. If you are unable to prescribe opioid agonist therapy, refer the person to a care provider or organization that can initiate treatment within no more than 3 days of diagnosis.

For Health Services
Ensure systems, processes, and policies are in place to allow people to receive opioid agonist therapy within 3 days of diagnosis regardless of where they present for treatment (whether hospital, residential addiction treatment facility, or correctional facility). No one with opioid use disorder receiving opioid agonist therapy should be refused access to any type of treatment (including inpatient addiction services). If an organization is not able to provide opioid agonist therapy (e.g., if no physicians or nurse practitioners are available), the organization should partner with an organization or clinician able to provide on-site access to opioid agonist therapy.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who receive opioid agonist therapy within 3 days of diagnosis

- Denominator: total number of people with opioid use disorder
- Numerator: total number of people in the denominator who are offered opioid agonist therapy within 3 days of diagnosis
- Data source: local data collection

Structural Indicator

Local availability of access to opioid agonist therapy

- Data sources: local data collection, ConnexOntario

Quality Statement 8: Concurrent Mental Health Disorders

People with opioid use disorder who also have a mental health disorder are offered concurrent treatment for their mental health disorder.

Background

Individuals, families, and communities affected by opioid use disorder face high rates of concurrent mental illness.[9] Management of opioid use disorder should always include a mental health assessment and appropriate treatment and referral for concurrent mental health disorders (see also statements 2 and 3).

Source: National Institute for Health and Care Excellence, 2007[9]

Definitions Used Within This Statement

Mental health disorder
Common mental health disorders include major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

Treatment for mental health disorders
Specific psychological and pharmacological interventions for the treatment of mental health disorders are out of scope for this quality standard. Detailed guidance on effective treatments for mental health disorders are available in other guidance sources, including Health Quality Ontario's *Major Depression* quality standard.

What This Quality Statement Means

For People With Opioid Use Disorder
If you have opioid use disorder and a mental health disorder, like depression or anxiety, your care provider should offer or arrange for treatment of both your opioid use disorder and your mental health disorder at the same time.

For Care Providers
If the person you are treating for opioid use disorder also has a mental health disorder, you should facilitate concurrent treatment for their mental health disorder.

For Health Services
Ensure systems, processes, and policies are in place to allow people receiving treatment for opioid use disorder to receive concurrent treatment for mental health disorders.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder and a mental health disorder who are offered concurrent treatment for their mental health disorder

- Denominator: total number of people with opioid use disorder who have a mental health disorder
- Numerator: total number of people in the denominator who are offered concurrent treatment for their mental health disorder
- Data source: local data collection

Quality Statement 9: Treatment of Opioid Withdrawal Symptoms

People with opioid use disorder who are in at least moderate withdrawal from opioids are offered relief of their symptoms with buprenorphine/naloxone within 2 hours.

Background

Buprenorphine/naloxone can precipitate withdrawal in individuals who have recently used opioids; therefore, symptoms of withdrawal should be of at least moderate intensity before buprenorphine/naloxone is given.[12,19] Buprenorphine/naloxone is more effective than clonidine or lofexidine in ameliorating symptoms of withdrawal and is associated with fewer side effects.[21]

Once acute withdrawal has been treated, care providers should focus on addressing the person's long-term treatment and harm reduction goals and refer them to appropriate resources as necessary. If a person opts for opioid agonist therapy, bridging treatment with buprenorphine/naloxone should be offered until their follow-up appointment, which should occur within 3 days.

Source: Advisory committee consensus

Definitions Used Within This Statement

Moderate withdrawal
Withdrawal symptoms occur when a person has either been administered an opioid antagonist (i.e., naloxone) or there is a reduction or cessation of opioid use following regular use. Common withdrawal symptoms include the following[1]:

- Diarrhea
- Dysphoric mood
- Insomnia
- Irritability
- Lacrimation or rhinorrhea
- Muscle aches
- Nausea or vomiting
- Piloerection
- Pupillary dilation
- Restlessness
- Sweating
- Yawning

The Clinical Opiate Withdrawal Scale can be used to assess the severity of withdrawal symptoms. Points are attributed to symptom severity, with a total score of 5 to 12 indicating mild withdrawal, 13 to 24 indicating moderate withdrawal, 25 to 36 indicating moderately severe withdrawal, and more than 36 indicating severe withdrawal.[22]

What This Quality Statement Means

For People With Opioid Use Disorder
If you are feeling sick because you have not had opioids for a while, you might be experiencing withdrawal. You can go to your care provider to get help to feel better. If your care provider says that you are experiencing moderate withdrawal, they will make sure you get medication within 2 hours to help you feel better. Once you are feeling better, your care provider will talk to you about different ways to manage your opioid use disorder and ways to reduce your risk of harm.

For Care Providers
If a person presents with at least moderate symptoms of opioid withdrawal, offer treatment within 2 hours of presentation. Buprenorphine/naloxone is the suggested first-line treatment for withdrawal symptoms. Once the acute withdrawal has been treated, discuss the person's goals for long-term treatment and harm reduction, and refer them to appropriate resources as necessary.

For Health Services
Ensure systems, processes, and resources are in place such that care providers are able to provide people with opioid use disorder immediate access to treatment for opioid withdrawal. This includes having policies in place to enable care providers to provide buprenorphine/naloxone quickly to relieve opioid withdrawal symptoms and to refer patients to the appropriate resources following symptom control.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder in moderate to severe withdrawal who receive buprenorphine/naloxone within 2 hours of presentation

- Denominator: total number of people with opioid use disorder in moderate to severe withdrawal
- Numerator: total number of people in the denominator who receive buprenorphine/naloxone within 2 hours of presentation
- Data source: local data collection

Quality Statement 10: Tapering Off of Opioid Agonist Therapy

People with opioid use disorder who have achieved sustained stability on opioid agonist therapy who wish to taper off are supported in a collaborative slow taper if clinically appropriate.

Background

Stability in treatment is attained once a person with opioid use disorder is functioning well on an optimal dose of opioid agonist therapy. An optimal dose is one that allows a person to be free of opioid withdrawal symptoms and cravings for the full 24-hour dosing interval without experiencing intoxication or sedation from the medication.[12]

Once stability is achieved, the frequency of a person's routine visits with a care provider for opioid agonist therapy should be reassessed. Care providers should consider the balance between safety and the potential burden that the visits have on the person's quality of life.[19]

Folloiwng a period of sustained stability, some people may want to taper off of opioid agonist therapy. The ideal duration of stability before tapering off depends on the duration and severity of a person's opioid use disorder and instability. For example, those with a long history of opioid use may require a longer period of regular opioid agonist therapy before tapering than those with a shorter history of opioid use. Some people may not be appropriate for tapering and should be encouraged to continue their opioid agonist therapy indefinitely.[12,19]

Following a successful collaborative slow taper, all people, even those who have been stable for many years, should be counselled on the risks of overdose owing to reduced tolerance, provided with naloxone, and taught how to administer it and how to recognize and respond to emergencies.[18]

Source: British Columbia Centre on Substance Use, 2017[12]

Definitions Used Within This Quality Statement

Clinically appropriate

Determining clinical appropriateness for tapering off of opioid agonist therapy includes considering the many factors that may reduce the risk of relapse following the taper; for example, duration of stability, duration of abstinence from substance use, absence of current or untreated psychiatric comorbidity, and the presence of strong supportive social networks.

Collaborative slow taper

A collaborative slow taper is a period of about 12 months during which a patient works with their care provider to establish an appropriate rate for tapering.[12] Patients have the right to stop tapering or reduce the rate of tapering at any point.

What This Quality Statement Means

For People With Opioid Use Disorder
If you are on opioid agonist therapy and you are feeling better, you or your care provider may suggest slowly lowering the dose of your medication over time. This is called tapering, and the goal is to eventually stop your opioid agonist therapy. Tapering may be considered when:

- You feel comfortable with the dose you are on
- Your health and social functioning have gotten better
- You want to stop taking opioid agonist therapy

But if tapering your opioid agonist therapy would likely not be a good option for you, your care provider may recommend continuing with your regular opioid agonist therapy.

For Care Providers
When a person wishes to stop opioid agonist therapy, and if clinically appropriate, support them in a collaborative slow taper of opioid agonist therapy to discontinuation.

For Health Services
Ensure supports are in place to allow people on opioid agonist therapy to achieve improved mental health and social functioning. This will help people gain stability and provide an environment where a collaborative slow taper to discontinuation is possible for appropriate people.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who wish to discontinue opioid agonist therapy when it is clinically appropiate and are undergoing a taper off of their opioid agonist therapy

- Denominator: total number of people with opioid use disorder who wish to discontinue opioid agonist therapy when it is clinically appropriate
- Numerator: total number of people in the denominator who are undergoing a taper off of their opioid agonist therapy
- Data source: local data collection

Quality Statement 11: Harm Reduction

People with opioid use disorder have same-day access to harm reduction services. A comprehensive harm reduction approach includes education, safe supplies, infectious disease testing, vaccinations, appropriate referrals, and supervised consumption services.

Background

Harm reduction strategies are practices, programs, and policies that aim to reduce the adverse health, social, and economic consequences of substance use without requiring a person to abstain from substance use.[11] Care providers and treatment programs for opioid use disorder should be guided by a harm reduction approach that enables immediate access to education and same-day access to harm reduction services as necessary.

Sources: Advisory committee consensus (same-day access) | British Columbia Centre on Substance Use, 2017[12] | National Institute for Health and Care Excellence, 2007[9] | Registered Nurses' Association of Ontario, 2015[11]

Definitions Used Within This Statement

Appropriate referrals
Referrals appropriate for people with opioid use disorder include those for human immunodeficiency virus (HIV) and hepatitis C treatment, other substance use, and housing services.[23]

Education
Information should be provided to people with opioid use disorder on how to reduce the risk of the following[24]:

- Acquiring HIV, hepatitis B, hepatitis C, and other pathogens
- Drug poisoning
- Soft-tissue injuries
- Other harms associated with drug consumption

Infectious disease testing
Testing should be performed for HIV, hepatitis B, hepatitis C, sexually transmitted infections, and tuberculosis.[9,23,24]

Safe supplies
Safe supplies for the use of opioids and other substances include the following: glass stems, screens, mouthpieces, push sticks, foil, meth pipes, needles and syringes, cookers, filters, ascorbic acid, sterile water, alcohol swabs, tourniquets, safe disposal containers, and condoms.[24]

Supervised consumption services
Supervised consumption services are spaces designated exempt from the Controlled Drugs and Substances Act. In these spaces, people can consume illicit drugs in a safe, supportive, hygienic environment under the supervision of staff who can intervene in the event of an overdose or other adverse event. Staff can also offer assessment and education and encourage engagement with or provide referral to other health or treatment services.

Vaccinations
Vaccinations that are suggested for people with opioid use disorder include those for diphtheria, hepatitis A, hepatitis B, influenza, pneumococcal pneumonia, and tetanus.[9,23,24]

What This Quality Statement Means

For People With Opioid Use Disorder
Your care provider may talk to you about harm reduction strategies. These are ways to reduce your chances of getting an infection, having an overdose, or dying from using opioids. They include:

- Information about how to be as safe as possible while taking opioids
- Access to, safe supplies, like clean needles and alcohol swabs
- Vaccinations for preventable illnesses like hepatitis B
- Tests for infections like HIV, hepatitis B, and hepatitis C
- Referrals to other health care services you might want or need

Not everyone will want or need these services, but if you do, you should be able to get them the same day you ask for them.

For Care Providers
Offer all people with opioid use disorder education on harm reduction. Provide people with safe supplies if requested. Where appropriate, encourage infectious disease testing and vaccinations. For those testing positive for infectious diseases, arrange timely referrals to appropriate medical care. For those likely to benefit from supervised consumption services, provide information on these services and offer to facilitate access to them.

For Health Services
Ensure systems, processes, and resources are in place such that every person with opioid use disorder has immediate access to harm reduction education and same-day access to harm reduction services either on site or via referral.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who reported receiving harm reduction services within 24 hours of request

- Denominator: total number of people with opioid use disorder who requested harm reduction services
- Numerator: total number of people in the denominator who reported receiving harm reduction services within 24 hours
- Data source: local data collection

Structural Indicator

Local availability of same-day access to harm reduction services

- Data source: local data collection

Emerging Practice Statement: Pharmacological Treatment Options for People With Opioid Use Disorder and Treatment Options for Adolescents

What Is an Emerging Practice Statement?

An emerging practice statement describes an area for quality improvement that has been prioritized by the advisory committee but for which there is insufficient or inconsistent evidence in the guidelines used in the development of the quality statements. An emerging practice statement acknowledges that there is a need for evidence-based guidance to be developed in an area, but the evidence base in this area is still emerging.

Rationale

Additional Opioid Agonist Therapy Options
For people with opioid use disorder who have been offered traditional opioid agonist therapy (both buprenorphine/naloxone and methadone) and had suboptimal results, or who do not wish to take these treatments, there may be added value in considereing other opioids within the context of a harm reduction framework. This could include prescribed oral opioids, prescribed injection opioids, or supervised consumption of non-prescription opioids.

Opioid Antagonist Therapy
For people with opioid use disorder who are no longer taking opioids (including opioid agonist therapy), opioid antagonists such as naltrexone may assist in preventing relapse to opioid use. Novel delivery systems, including extended-release formulations and long-acting implants, show more promise than the oral naltrexone currently available in Canada.[12]

Treatment Options for people under 16 years of age
The guidelines used to develop this quality standard were based on studies conducted with adult populations. This quality standard may be of benefit to adolescents with moderate to severe opioid use disorder, but there is insufficient evidence to be sure what high-quality care looks like for this age group.

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Advisory Committee

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Mae Katt (co-chair)
Primary Health Care Nurse Practitioner

Sheryl Spithoff (co-chair)
Family Physician and Addiction Medicine Physician,
Women's College Hospital

Debbie Bang
Manager,
St. Joseph's Healthcare Hamilton

Rob Boyd
Oasis Program Director,
Sandy Hill Community Health Centre

Sharon Cirone
Physician, Privileges at St. Joseph's Health Centre and Sioux Lookout Meno Ya Win Health Centre

Kim Corace
Director,
Clinical Programming and Research Substance Use and Concurrent Disorders Program,
The Royal Ottawa Mental Health Centre

Mike Franklyn
Family Physician,
Private Practice

Deborah Gatenby
Chief Executive Officer,
Hope Place Centres

Kristel Gutherie
Health Promotion Specialist,
Toronto Public Health

Meldon Kahan
Medical Director,
Substance Use Services,
Women's College Hospital

Lori Kiefer
Senior Medical Consultant,
Ministry of Community Safety and Correctional Services

Michelle Klaiman
Emergency Physician and Addiction Medicine Consultant,
St. Michael's Hospital

Sharon Koivu
Physician Consultant,
Palliative Care,
London Health Sciences Centre

Betty-Lou Kristy
Peer Support Substance Use System Lead,
Halton TEACH (Teach, Empower, Advocate Community Health)

Wiplove Lamba
Addiction Psychiatrist,
St. Michael's Hospital

Bernard Le Foll
Medical Head, Addiction Medicine Service and Medical Withdrawal Service,
Centre for Addiction and Mental Health

Pamela Leece
Public Health Physician,
Public Health Ontario

Donna May
Founder, MumsDU

Kristine Quaid
Peer Supporter,
St. Joseph's Care Group

Beth Sproule
ClinicianScientist,
Pharmacy,
Centre for Addiction and Mental Health

Sue Tobin
Nurse Practitioner, Lead and Clinical Administrator,
Ingersoll Nurse Practitioner–Led Clinic

Stephanie Venneri
Program Manager,
Breakaway Addiction Services

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About Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by this single-minded purpose: **Better health for all Ontarians.**

Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voices of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large-scale quality improvements—by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters

We recognize that, as a system there is much to be proud of, but also that it often falls short of being the best it can be. Plus, certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

Looking for more information?

Visit our website at **hqontario.ca** and contact us at **qualitystandards@hqontario.ca** if you have any questions or feedback about this guide.

Health Quality Ontario
130 Bloor Street West, 10th Floor
Toronto, Ontario
M5S 1N5

Tel: 416-323-6868
Toll Free: 1-866-623-6868
Fax: 416-323-9261
Email: QualityStandards@hqontario.ca
Website: hqontario.ca

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